2100. FREE CHOICE OF PROVIDERS - GENERAL

The purpose of the free choice provision is to allow title XIX recipients the same opportunities to choose among available providers of covered health care and services as are normally offered to the general population. This means that title XIX recipients are subject to the same reasonable limitations in exercising such choice as are nonrecipients.

Under §1902(a)(23) of the Social Security Act, a State plan for medical assistance under title XIX must provide that any individual eligible for medical assistance (including drugs) under the plan may obtain the services available under the plan from any institution, agency, community pharmacy, or practitioner qualified to perform the services required, who undertakes to provide him these services, including an organization which provides such services or arranges for their availability on a prepayment basis. This requirement does not apply in the case of Puerto Rico, the Virgin Islands, and Guam. The agency is not prohibited from:

- imposing reasonable and objective qualification standards for provider eligibility,

- establishing the fees which will be paid to providers for furnishing medical and remedial care under the plan, or

- restricting the free choice of providers in accordance with one or more of the exceptions provided for under §1915(a) or under a waiver as provided for under §1915(b).

This provision is implemented in regulations at 42 CFR 431.51.

Section 2175 of Public Law 97-35 added §1915 to the Social Security Act. Section 1915 allows exceptions to and waivers of the freedom of choice provision as described in §§2103 and 2104.

2101. INFORMING BENEFICIARIES

Under §1902(a)(23) of the Act and 42 CFR 435.905, Medicaid beneficiaries must be furnished with information and advice about benefits available under the State plan and how to obtain them, and must be informed about the nature and extent of their rights under the freedom of choice provision. Specifically, advise beneficiaries that they can choose to receive their health care services from any provider participating in the State Medicaid program. Include in the information any limitations on services, including any requirements for prior authorization, and any limits on services, such as limits on the number of outpatient hospital days that can be used without special authorization from the Medicaid program. Include with this information a statement about their right to request a hearing before the State agency, as required under §1902(a)(3), if they believe their free choice of provider has been denied or impaired, without due process.

Medicaid agencies are encouraged to help beneficiaries obtain the medical care and services they need. The amount and type of help needed will vary depending on the individual situation. If possible, you may provide each eligible individual, before the need for medical services arises, with an up-to-date referral list of all local participating vendors, particularly physicians and pharmacists, and also including hospitals, health maintenance organizations, (HMOs) prepaid health plans, nursing homes, and laboratories. The list may include notations of types of services provided, business hours, location, phone number, etc. This information can be gathered from records of providers who have signed agreements to participate in the program or who have submitted claims for reimbursement for services. It is recommended that this be done during the intake process. You are urged to make information of this type available to all new applicants through the use of written material or orally, if appropriate.

When it is not feasible to provide each individual recipient with a list of available providers, the information should at least be available from the State or local agency. If possible, designate staff responsibility for assuring that recipients are aware of the services available to them, and that the information provided is accurate and up-to-date. In addition, make arrangements to provide information to beneficiaries who do not read or speak English.

The establishment of procedures for getting feedback from beneficiaries relating to accessibility and availability of care under the plan is encouraged.

2102. CONTRACTUAL ARRANGEMENTS

A. Package Plan for Medical Care.--Some medical services which are usually furnished on a fee-for-service basis may occasionally be provided as part of a package of medical care. Package plans may be offered by providers such as physicians, hospitals, and nursing homes, as well as neighborhood health centers, group practice organizations, HMOs and prepaid health plans.

In the absence of an applicable waiver, participation in any package plan for medical care must be strictly voluntary. Once a recipient has chosen to receive the package of medical services offered by a particular plan, he has exercised his right of freedom of choice for all items of medical care included under the package, except for family planning services and supplies furnished to individuals of child bearing age who are eligible under the State plan. In the case of family planning services and supplies, the enrollment of a recipient in a primary care case management system (as described in §2107A), an HMO, or a similar entity does not restrict the choice of provider from whom the recipient may receive family planning services and supplies.

Assure that the terms of membership are fully and clearly explained, so recipients are aware of the limitations on their right of free choice of providers for services available under the plan.

B. Provision of Materials to Providers.--Freedom of choice does not apply in instances where the providers' customary practice is to obtain, by contractual arrangement with manufacturers or distributors, supplies or equipment which are not ordinarily purchased directly by the general population and whose cost is included in the providers' fee. For example, you may contract with a manufacturer to furnish eyeglass lenses to an optician. Even though the beneficiary could select his own optometrist he would not be free to choose the kind of lenses he receives. This would not violate freedom of choice. This would be true for such things as dentures, eyeglass lenses, medications which cannot be self-administered, and certain types of laboratory services.

C. Prepayment Contracting Under Section 1915(b) Waivers.--States requesting waivers under section 1915(b) of the Act may wish to enter into prepayment arrangements to provide incentives for cost-effective and efficient performance. However, in implementing such arrangements, the State should assure that such prepayment contracts comply with applicable Federal requirements. Different requirements apply to risk and nonrisk contracts and depend on the legal status of the organization. The regulations governing these contracts are specified in 42 CFR Part 434.

D. Risk Contract Requirements.--Organizations that provide services on a risk basis are referred to in the regulations as either health maintenance organizations (HMOs) or prepaid health plans (PHPs) (42 CFR 434). If the contract with the provider is for comprehensive services (i.e., the scope of services in section 1903(m)(2)(A) of the Act), the contractor must either meet the HMO definition in the regulations or be one of several organizations listed in section 1903(m)(2)(B) of the Act (i.e., these organizations were "grandfathered" by the law into eligibility for contracts for comprehensive services in 1976). The regulations describe these organizations as risk-basis PHPs (42 CFR 434.2). Contracts on a risk basis for other than a comprehensive package of services are also governed by the risk PHP regulations. Section l9l5(b) does not generally authorize waivers to the HMO regulations; however, the PHP regulations may be waived under section l9l5(b) under certain circumstances (see also 42 CFR 434.26(b)(3)).

Beneficiaries are entitled to their choice of health professional in both HMOs and PHPs (risk and non-risk) to the extent that freedom of choice is possible and appropriate.

If the HMO or PHP contract does not cover all services available under the plan, the agency must arrange for services not included to be available and accessible. This may be done for example by having the HMO or PHP refer beneficiaries to other providers.

A beneficiary has the right to terminate his enrollment in an HMO at any time, effective no later than the first day of the second month after the month in which he or she requests termination. Individuals must be informed of this right by the HMO at the time of enrollment.

E. Nonrisk Contracts.--Organizations with capitation contracts in which the contractor is not at risk are described in the regulations as nonrisk PHPs (42 CFR 434.2). The main difference from the risk-PHP regulations is found in the upper payment limits (42 CFR 447.361-447.362).

F. Health Insuring Organizations.--State contracts on a risk basis with organizations that pay for services (rather than provide services) are governed by the health insuring organization (HIO) regulations in 42 CFR 434.14. An HIO is not a provider of services and, therefore, while the HIO may arrange (e.g., through contracts) for services to be available in a given area, for groups of recipients, the HIO may not generally make arrangements on an individual recipient basis; nor may it assume a medical responsibility for services. The usual Medicaid contracting rules (e.g., including competitive bidding) apply to HIO contracts. Under an HIO contract, beneficiaries are given the same freedom-of-choice options they would have if the State were paying expenses directly; these may be waived under a l9l5(b) waiver program.

2103. EXCEPTIONS TO FREEDOM OF CHOICE

Under section 1915(a) of the Act, a State shall not be deemed to be out of compliance with the requirements of 1902(a)(23), the free choice of provider, as well as 1902(a)(1) (statewideness), and 1902(a)(10) (comparability), solely by reason of certain allowable exceptions. These exceptions, as stated below, are implemented in regulations at 42 CFR 431.54.

A. Services On A Prepayment Basis.--If a State contracts on a prepayment basis with an organization (i.e., health maintenance organization or prepaid health plan) that provides services in addition to those offered under the State plan, it may restrict the provision of additional services to recipients who live in the area served by the organization and who elect to obtain such services from the organization by enrolling in it.

B. Rural Health Clinic Services.--A State may require in its State plan that payment will be made for rural health clinic services only if those services are provided by a rural health clinic.

C. Competitive Arrangements.--A State may enter into arrangements to purchase other laboratory services and x-ray services (as defined at 42 CFR 440.30) and medical devices for availability to Medicaid beneficiaries. These arrangements may be through a competitive bidding process or otherwise. The State must submit a certification to HCFA assuring, and the Secretary must find:

1. that adequate services or devices are available to recipients under the arrangements.

2. that laboratory services purchased are provided through independent laboratories, hospital laboratories (in- or outpatient) that provide services for nonhospital patients, and physician laboratories that process at least 100 specimens during any calendar year from other physicians. These laboratories must meet the Medicare conditions for participation. Laboratories requiring an interstate license under 42 CFR Part 74 must be licensed by HCFA or receive an exemption from the licensing requirement by the College of American Pathologists.

Hospital and physician laboratories may participate in competitive bidding only with regard to services to nonhospital patients and other physicians' patients, respectively; and

3. that the laboratory has no more than 75 percent of its charges based on services to beneficiaries of Medicaid or Medicare.

D. Lock-in of Beneficaries Who Over-Utilize Services.--A State may lock-in a beneficiary who has utilized Medicaid services or items at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, to a single provider or limited group of providers for a reasonable period of time. The beneficiary must be given notice and opportunity for a hearing before lock-in and must be assured reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality. The lock-in does not apply to emergency services furnished the beneficiaries.

If you had a lock-in program approved prior to the enactment of §1915(a) of the Act, the program is subject to the new statutory requirements.

E. Lock-Out of Providers.--If you find that a provider has abused the Medicaid program, you may restrict the provider, through suspension or otherwise, from participating in the Medicaid program for a reasonable period of time, subject to the following limitations.

o Before imposing any restriction, give the provider notice and the opportunity for a hearing. You may develop your own procedures providing those procedures afford adequate notice and a meaningful opportunity to be heard.

o Before restricting a provider, you must find that, in a significant number or proportion of cases, the provider has:

--provided Medicaid items or services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the agency, or

--provided Medicaid items or services of a quality that does not meet professionally recognized standards of health care.

o Notify the RO when you impose a restriction and give a general notice to the public of the restriction and its duration.

o You may not impose restrictions which result in denying beneficiaries reasonable access (taking into account geographic location and travel time) to Medicaid services of adequate quality, including emergency services.

o All lock-out programs approved prior to the implementation of §1915(a) of the Act are subject to the §1915(a) requirements.

Several of these exceptions have a certification requirement. If you implement a project under competitive bidding or other arrangements, lock-in of beneficiaries, or lock-out of providers, certify to HCFA that the statutory safeguards and requirements for an exception under §1915(a) of the Act are met. In the case of lock-in or lock-out, submit the certification by the end of the quarter in which the project is implemented. In the case of competitive bidding or other arrangements, submit certification prior to instituting the project, since the Secretary must make certain findings before the project may be initiated. (See §2103 C.)

2104. WAIVER OF STATE PLAN REQUIREMENTS

Under §1915(b) of the Act, you may request that the Secretary waive the freedom of choice requirement §1902(a)(23) of the Act as well as other requirements of §1902 of the Act if necessary to implement a project described in §2107. Those sections of the Act most frequently waived, in addition to §1902(a)(23), are §1902(a)(1), statewideness, and §1902(a)(10), comparability requirements. However, you may not waive payment for services offered by public or federally qualified health centers (FQHCs), including ambulatory services, to all individuals who are entitled to FQHC services under the State plan. In addition, you may not waive §1902(s) of the Act, which provides for adjusted hospital payments for services provided to infants under age 1 and to children under age 6 in a disproportionate share hospital.

HCFA approves waiver requests which are cost effective, efficient, and consistent with the purposes of the Medicaid program. See §2108 for performance standards for cost effective provision of services to be applied to waiver projects, as required by 42 CFR 431.55(b)(2)(i).

2105. CATEGORIES OF WAIVERS UNDER §1915(b)

Waivers of requirements of §1902 of the Act may be requested under §1915(b) of the Act. Those sections most frequently waived include §1902(a)(1) on statewideness, §1902(a)(10) on comparability of services, and §1902(a)(23) on recipients' free choice of providers. Other sections which may require waiver include §1902(a)(30) on upper payment limits (with regard to subcontractors, but not the overall program) and §1902(a)(4), insofar as this section is the statutory basis for regulations on coverage and enrollment requirements for Prepaid Health Plans (PHPs). Provisions of title XIX other than §1902 of the Act provisions may not be waived. Examples are §1903(m) requirements relating to HMOs and §1916 requirements relating to enrollment fees, premiums, deductions, cost sharing, and similar charges.

No waiver under §1915(b) may restrict the choice of the individual in receiving family planning services under §1905(a)(4)(C).

Section 1915(b) waivers may be granted only for one or more of the following purposes in subsections A - D.

A. Section 1915(b)(1)--Primary Care Case Management Systems (PCCM) or Specialty Physician Services Arrangements.--This section allows you to implement PCCM systems or specialty physician services arrangements, under which you may restrict the provider from or through whom a recipient can obtain medical care services.

Under a PCCM, you must assure that a specific person or an agency (the case manager) is responsible for locating, coordinating, and monitoring all primary care and other medical services and rehabilitative services on behalf of recipients involved in the program. Primary care is ordinarily provided by family practice physicians, internists, pediatricians, obstetricians, or physician surrogates (e.g., physician assistants, nurse practitioners, pediatric associates), and may include the provision of, or arrangements for, all available services as long as primary care services are provided as well.

A specialty services arrangement allows you to restrict recipients of specialty services to designated providers, even in the absence of a PCCM, e.g., restricting recipients in need of maternity related services to specific clinics.

Emergency services may not be restricted under one of these waivers, nor may the program substantially impair recipients' access to services of adequate quality.

Access to FQHC services may not be restricted under one of these waivers. However, you may require that such services be coordinated through the case manager to assure the proper management of all primary care and other medical and rehabilitative services provided to recipients involved in the program.

B. Section 1915(b)(2)--Locality as Central Broker.--With a waiver under this provision, a locality may act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

Under this provision, a locality is any defined jurisdiction, e.g., district, town, city, borough, county, parish or State, and may utilize any agency or agent, public or private, profit or nonprofit, to act on its behalf in carrying out its central broker function. A request must specify who is acting as the locality's broker and may not substantially impair recipients' access to services of adequate quality.

C. Section 1915(b)(3) - Sharing of Cost Savings.--Under this provision, you may share cost savings resulting from the use of more cost effective medical care with recipients by providing them with additional services.

Additional services provided under a §1915(b)(3) waiver may be in the form of services not otherwise provided in the State plan or the elimination of copayments or service limitations. These services may include those offered by plans selected by recipients, as well as those offered expressly by you as an inducement for recipients to participate in a PCCM, a competing health care plan, or other arrangements that result in the more cost effective medical care.

No §1915(b)(3) waiver request is required if a Medicaid agency contracts on a prepayment basis with an organization which provides additional services to those offered in the State plan as long as the offer is consistent with 42 CFR 434.20(d) and 440.250(g).

D. Section 1915(b)(4) - Restriction of Recipients to Specified Providers.-Under this provision, you may require recipients to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. For example, §1915(b)(4) of the Act must be requested if you wish to completely eliminate the fee for service option by having the covered waiver population choose between two or more HMO providers. This provision must also be used if you wish to use competitive bidding in selecting the most cost effective and efficient providers of a service, e.g., inpatient hospital services, drugs, or transportation.

These restrictions may not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing these services. In this context, demonstrated effectiveness and efficiency refer to reducing costs or slowing the rate of increase of costs and maximizing outputs or outcomes per unit of cost. The restrictions also may not apply in emergency circumstances. Further, providers under such restrictions are to be paid on a timely basis in the same manner as health care practitioners must be paid under §1902(a)(37)(A) of the Act.

2106. HOW TO SUBMIT REQUEST FOR WAIVER UNDER §1915(b)

2106.1 General Requirements.--HCFA considers only waiver requests submitted by or through the Governor, State cabinet members responsible for State Medicaid agency activities, the Director of the State Medicaid agency, or by someone with the authority to submit waiver requests on behalf of the Director.

Submit an original and four copies of initial waiver requests, modification requests, and renewal requests to the Director of the Office of Managed Care in HCFA central office (CO). Also, send one copy of those requests to the HCFA RO at the same time. The RO reviews the request and forwards a

recommendation to HCFA CO for further review. Final approval is made by the HCFA Director of the Office of Managed Care. Disapproval of the request is made by the HCFA Administrator, although the DHHS Secretary is consulted on disapprovals.

A waiver request submitted under §1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary denies such requests in writing or informs you in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of receipt of your response to the request for additional information, or the waiver request is deemed to have been granted.

The 90-day time period begins (i.e., day number one) on the day the waiver is received by the addressee (i.e., the Secretary, the HCFA Administrator, the RO, or the Office of Managed Care) and ends 90 calendar days later (counting the date of receipt as day number one). The running of the time period is stopped if additional information is requested in writing. A new 90-day period begins when the requested information is received, and HCFA must then either approve or disapprove the request.

Section 1915(b) waivers are approved for a period no longer than two years. However, upon your request, a waiver authority may be renewed for additional periods not to exceed two years each. (See §2110 for information on requests for renewal of waiver authority.) Waiver renewal requests must either be approved or disapproved within one 90-day time period unless additional information is requested. A new 90 day period begins when the State's response to the additional information request is received by HCFA.

2106.2 Coordination with HCFA RO.--You are encouraged to contact the HCFA RO staff for guidance in preparing waiver requests in accordance with statutory and regulatory requirements. RO assistance during the planning of the proposal and review prior to submission of the proposal helps to resolve problems in the early stages and aids in the expeditious processing and approval of the waiver. In addition, the RO staff is aware of the types of programs that are being proposed and implemented by other States, and this information could be useful in developing an approvable waiver program. Submission of the proposal in draft to the RO also helps resolve problems and expedite the approval process.